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1982 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

COMMUNICATION

FROM

BOARD OF TRUSTEES, FEDERAL HOSPITAL INSURANCE TRUST FUND

TRANSMITTING

THE 1982 ANNUAL REPORT OF THE BOARD, PURSUANT TO SECTION 1817(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

APRIL 5, 1982.—Referred to the Committee on Ways and Means and ordered to be printed

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LETTER OF TRANSMITTAL

Board of Trustees of the
Federal Hospital Insurance Trust Fund
Washington, D.C., April 1, 1982

THE SPEAKER OF THE HOUSE OF REPRESENTATIVES
Washington, D.C.

SIR: We have the honor to transmit to you the 1982 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (the 17th such report), in compliance with the provisions of section 1817(b) of the Social Security Act.

Respectfully,

DONALD T. REGAN,
Secretary of the Treasury,
and Managing Trustee of the Trust Fund

RAYMOND J. DONOVAN,
Secretary of Labor,
and Trustee

RICHARD S. SCHWEIKER,
Secretary of Health and Human Services,
and Trustee

CAROLYNE K. DAVIS, Ph.D.,
Administrator of the Health Care Financing Administration, and Secretary, Board of Trustees

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and Trustee

Richard S. Schweiker

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and Trustee

Carolyne K Davis

CAROLYNE K. DAVIS, Ph.D.,
Administrator of the Health Care Financing Administration, and Secretary, Board of Trustees

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1982 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

THE BOARD OF TRUSTEES

The Federal Hospital Insurance Trust Fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1817(b) of the Social Security Act, as amended. The Board is comprised of three members who serve in an ex officio capacity. The members of the Board are the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services. The Secretary of the Treasury is designated by law as the Managing Trustee. The Administrator of the Health Care Financing Administration is Secretary of the Board. The Board of Trustees reports to the Congress once each year in compliance with section 1817(b)(2) of the Social Security Act. This is the 1982 annual report, the seventeenth such report.

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HIGHLIGHTS

(a) Disbursements of the hospital insurance trust fund in fiscal year 1981 were $29.3 billion, an increase of 20.5 percent over fiscal year 1980. Most of this increase was due to a substantial rise in the utilization and in the cost of hospital services. Increases in both payroll and nonpayroll expenses in hospitals were greater than comparable increases in the general economy.

(b) Income to the trust fund amounted to $32.9 billion, representing an increase of 29.3 percent in fiscal year 1981 over 1980. The majority of this increase was due to increases in the tax rate and in the maximum amount of taxable earnings.

(c) The trust fund increased from $14.5 billion to $18.1 billion at the end of fiscal year 1981. The effective annual rate of interest earned by the assets of the hospital insurance trust fund for the year ending June 30, 1981, was 8.9 percent.

(d) The Secretary of Health and Human Services promulgated an inpatient deductible of $260 for calendar year 1982 and a monthly premium of $113 for noninsured enrollees for the 12-month period beginning July 1982.

(e) Approximately 25.1 million persons aged 65 and over were protected by the hospital insurance program in July 1981. An additional 3.0 million disabled beneficiaries had protection in the same month.

SOCIAL SECURITY AMENDMENTS SINCE THE 1981 TRUSTEES REPORT

Public Law 97-35, "The Omnibus Budget Reconciliation Act of 1981," which was enacted on August 13, 1981, contains many provisions having an impact on the Federal Hospital Insurance Trust Fund. They are:

(1) Up to 50 hospitals may be awarded a "transitional allowance" for the closure, or conversion to approved use, of underutilized beds or services. Any hospital seeking such a "transitional allowance" must seek prior approval of the closure or conversion plan. The plan must be consistent with findings of an appropriate health planning agency and with any applicable State program for reducing the number of beds in the State. Only private non-profit or local government hospitals are eligible for allowances based upon complete closure and the closure cannot be for the purpose of replacing the existing plant. Effective for services furnished during an accounting year beginning on or after October 1, 1982, until January 1, 1984.

(2) Payments due to a Medicare provider may be withheld to offset Medicaid overpayments. State Medicaid agencies would then be reimbursed from the amount received. Effective upon enactment.

(3) The Secretary is given authority to assess civil penalties against Medicare practitioners and providers for fraudulent practices. Authorized actions include imposition of a civil penalty of up to $2,000 for each fraudulently claimed item or service, assessment of up to twice the amount of the fraudulent portion of a claim in lieu of damages, and denial of participation in Medicare to persons filing fraudulent claims. Persons subject to a monetary penalty would be given written

notice and an opportunity for an administrative hearing prior to imposition of the penalty. Effective upon enactment.

(4) The coinsurance payment which is imposed after the 60th day of covered hospital care is based on the deductible in effect for the calendar year in which the services are rendered rather than the calendar year when the spell-of-illness began. Effective January 1, 1982.

(5) The base of the formula that is used to determine the HI deductible is raised from $40 to $45. Effective January 1, 1982.

(6) The routine nursing differential used in determining reasonable costs for routine hospital services is reduced from 8.5 percent to no more than 5 percent. This provision applies only to cost accounting periods ending, or that portion of the period occurring, after September 30, 1981.

(7) Reimbursement limits applied to hospital routine operating costs are reduced from 112 to 108 percent of the mean. This provision applies only to cost accounting periods ending, or that portion of the period occurring, after September 30, 1981.

(8) Reimbursement limits applied to home health agency costs are reduced from the 80th to the 75th percentile of the average cost per visit and calculated by type of service. This provision applies only to cost accounting periods ending, or that portion of the period occurring, after September 30, 1981.

(9) Medicare becomes the secondary payer for the first 12 months after an individual, who has private group employer health insurance, is eligible for Medicare benefits solely because of ESRD. Reimbursement is limited to Medicare's share of those covered costs not covered by the private plan.

Any Medicare payments for services during this period would be conditional on reimbursement to the program when payment is made by the plan. Effective October 1, 1981. Tax deductions paid or incurred by an employer are not allowed if the plan differentiates between benefits to ESRD beneficiaries and other individuals covered by the plan. Effective for taxable years beginning on or after January 1, 1982.

(10) Utilization guidelines for Medicare intermediaries are required to establish a program for them to review claims on a sample basis for home health services in order to monitor whether they meet coverage criteria. Effective October 1, 1981.

(11) The 12-month statutory limit on agreements with skilled nursing facilities (SNFs) is repealed. Effective upon enactment.

(12) Several provisions of P.L. 97-35 repealed or amended legislation passed in the "Omnibus Reconciliation Act of 1980," P.L. 96-499. They include:

(a) Repealed coverage of inpatient services provided in free-standing alcohol detoxification facilities. Effective for inpatient stays beginning the 10th day after enactment.

(b) Repealed the one-time deferral of the Periodic Interim Payment (PIP) method of reimbursement. Effective upon enactment.

(c) Repealed the inclusion of occupational therapy as a basis for initial entitlement to home health services. However, in those situations where a course of home health treatment has been instituted because a patient needed skilled nursing care or physical or speech therapy, home health services would be continued even though the patient no longer required any skilled

service other than occupational therapy. Effective for plans of treatment established beginning December 1, 1981.

(d) P.L. 96-499 exempted hospitals having an occupancy rate of over 80 percent from provisions limiting payment to hospitals for an inappropriate level of care. The occupancy test is no longer applicable. Instead, a non-public hospital's Medicare reimbursement would be reduced if there is an "excess capacity" of beds either in the institution or in the area.

Public Law 97-123, which was enacted on December 29, 1981, contained two provisions which have an impact on the Federal Hospital Insurance Trust Fund. They are:

(1) Interfund borrowing among the Federal Old Age and Survivors, the Federal Disability Insurance, and the Federal Hospital Insurance Trust Funds is permitted through December 1982 for the financing of mandated benefits. The loan cannot guarantee the payment of benefits more than six months in advance and must be repaid to the lending fund with interest equal to the interest the lending fund would have earned on the loan. The amount of any loan and the repayment schedule is determined by the Managing Trustee. Effective upon enactment.

(2) Social Security coverage was extended to the first six months of sick pay including payments by insurance companies and payments under State temporary disability insurance laws. Payments for non-work-related temporary disability paid under the Railroad Unemployment Insurance Act are similarly treated as taxable compensation under the Railroad Retirement Tax Act. Any portion of such sickness benefits paid for by employee contributions are not covered.

NATURE OF THE TRUST FUND

The Federal Hospital Insurance Trust Fund was established on July 30, 1965, as a separate account in the United States Treasury. All the financial operations of the hospital insurance program are handled through this fund.

The major sources of receipts of the trust fund are (1) amounts appropriated to it under permanent appropriation on the basis of contributions paid by workers and their employers, and by individuals with self-employment income, in work covered by the hospital insurance program and (2) amounts deposited in it representing contributions paid by workers employed by State and local governments and by such employers with respect to work covered by the program. The coverage of the hospital insurance program includes workers covered under the old-age, survivors, and disability insurance program and those covered under the railroad retirement program.

All employees, and their employers, in employment covered by the program are required to pay contributions with respect to the wages of individual workers. Cash tips, covered as wages beginning in 1966 under the 1965 amendments, are an exception. Employees pay contributions with respect to cash tips but, prior to 1978, employers did not. Beginning in 1978, under the 1977 amendments, employers are required to pay contributions on that part of the tip income deemed to be wages under the Federal minimum wage law. All covered self-employed persons are required to pay contributions with respect to their self-employment income.

In general, an individual's contributions are computed on annual wages or self-employment income, or both wages and self-employment income combined, up to a specified maximum annual amount, with the contributions being determined first on the wages and then on any self-employment income up to the maximum annual amount.

The hospital insurance contribution rates applicable to taxable earnings in each of the calendar years 1966 and later are shown in table 1. For 1983 and later, the contribution rates shown are the rates scheduled in the provisions of present law. The maximum amount of annual earnings taxable in each year 1966-82 are also shown. For 1975-78, the contribution and benefit bases were determined under the automatic increase provisions in section 230 of the Social Security Act. In 1979, 1980, and 1981, the bases increased to the specified amounts as provided under the 1977 amendments. After 1981, the automatic increase provisions are again applicable.

Except for amounts received under State agreements (to effectuate coverage under the program for State and local government employees) and deposited directly in the trust fund, all contributions are collected by the Internal Revenue Service and deposited in the general fund of the Treasury as internal revenue collections. The contributions received are immediately and automatically appropriated to the trust fund, on an estimated basis. The exact amount of contributions received is not known initially since hospital insurance contributions, old-age, survivors, and disability insurance contributions, and individual income taxes are

not separately identified in collection reports received by the Treasury Department. Periodic adjustments are subsequently made to the extent that the estimates are found to differ from the amounts of contributions actually payable on the basis of reported earnings.

An employee who worked for more than one employer during the course of a year and paid contributions on wages in excess of the statutory maximum can receive a refund of the contributions he paid on such excess wages. The amount of contributions subject to refund for any period is a charge against the trust fund.

Another source from which receipts of the trust fund are derived is interest received on investments held by the fund. The investment procedures of the fund are described later in this section.

The income and expenditures of the trust fund are also affected by the provisions of the Railroad Retirement Act which provide for a system of coordination and financial interchange between the railroad retirement program and the hospital insurance program.

Sections 217(g) and 229(b) of the Social Security Act authorize annual reimbursements from the general fund of the Treasury to the hospital insurance trust fund for any costs arising from the granting of noncontributory wage credits for military service, according to periodic determinations made by the Secretary of Health and Human Services.

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Section 231 of the Social Security Act authorizes reimbursement from the general fund of the Treasury to the hospital insurance trust fund for any costs arising from the granting of noncontributory wage credits to individuals who were interned during World War II at a place within the United States operated by the Federal Government for the internment of persons of Japanese ancestry.

Under section 103 of the Social Security Amendments of 1965, hospital insurance benefits are provided to certain uninsured persons aged 65 and over. Such payments are made initially from the hospital insurance trust fund, with reimbursement from the general fund of the Treasury for the costs, including administrative expenses, of the payments. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.

Section 1818 of the Social Security Act provides that certain persons not eligible for hospital insurance protection either on an insured basis or on the uninsured basis described in the previous paragraph may obtain protection by enrolling in the program and paying a monthly premium.

Section 201(i) of the Social Security Act authorizes the Managing Trustee to accept and deposit in the trust fund unconditional money gifts or bequests made for the benefit of the fund or any activity financed through the fund.

Expenditures for benefit payments and administrative expenses under the hospital insurance program are paid from the trust fund. All expenses incurred by the Department of Health and Human Services and by the Treasury Department in carrying out the provisions of title XVIII of the Social Security Act pertaining to the hospital insurance program and of the Internal Revenue Code relating to the collection of contributions are charged to the trust fund. The Secretary of Health and Human Services certifies benefit payments to the Managing Trustee, who makes the payments from the trust fund in accordance therewith.

Hospitals, at their option, are permitted to combine their billing for both hospital and physician components of radiology and pathology services rendered hospital inpatients by hospital-based physicians. Where hospitals elect this billing procedure, payments are made initially from the hospital insurance trust fund, with reimbursement from the supplementary medical insurance trust fund. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowance, as the actual experience develops and is analyzed.

The Social Security Amendments of 1972 provide that hospital admissions under all Federal Health Insurance programs be reviewed by Professional Standards Review Organizations. Under section 1168 of the Social Security Act, payments for the costs of such reviews are made initially from the hospital insurance trust fund, with reimbursement from the general fund of the Treasury for the costs of reviews of admissions covered under Federal programs other than the hospital insurance program. This provision was subsequently repealed.

The Social Security Amendments of 1967 and 1972 authorize the Secretary of Health and Human Services to develop and conduct a broad range of experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under the hopital insurance and supplementary medical insurance programs. A sizable portion of the costs of such experiments and demonstration projects are paid from the hospital insurance and supplementary medical insurance trust funds.

Congress has authorized expenditures from the trust funds for construction, rental, and lease or purchase contracts of office buildings and related facilities for use in connection with the administration of the hospital insurance program. Both the capital costs of construction financed directly through the trust funds and the rental, lease, or purchase contract costs of acquiring facilities are included in trust fund expenditures. In 1972-75, construction of several large facilities was authorized under purchase contract authority, wherein initial capital costs were borne by the private sector. Under this method of facilities acquisition, trust fund expenditures for use and ultimate Government ownership of a facility are made over periods of from 10 to 30 years. Whatever the manner of acquisition, the net worth of facilities and other fixed capital assets is not carried in the statement of the assets of the trust fund presented in this report. This is because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and, therefore, is not viewed as being a consideration in assessing the actuarial status of the funds.

That portion of the trust fund which, in the judgment of the Managing Trustee, is not required to meet current expenditures for benefits and administration is invested, on a daily basis, in interest-bearing obligations of the U.S. Government (including special public-debt obligations described below), in obligations guaranteed as to both principal and interest by the United States, or in certain federally-sponsored agency obligations that are designated in the laws authorizing their issuance as lawful investments for fiduciary and trust funds under the control and authority of the United States or any officer of the United States. These obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price.

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall bear interest at a rate based on the average market yield (computed on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such month.

TABLE 1.--CONTRIBUTION RATES AND MAXIMUM TAXABLE AMOUNT OF ANNUAL EARNINGS

Calendar Years	Maximum taxable amount of annual earnings	Contribution rate (Percent of taxable earnings) Employees and employers, each	Self-employed
Past experience:			
1966	$ 6,600	0.35	0.35
1967	6,600	0.50	0.50
1968-71	7,800	0.60	0.60
1972	9,000	0.60	0.60
1973	10,800	1.00	1.00
1974	13,200	0.90	0.90
1975	14,100	0.90	0.90
1976	15,300	0.90	0.90
1977	16,500	0.90	0.90
1978	17,700	1.00	1.00
1979	22,900	1.05	1.05
1980	25,900	1.05	1.05
1981	29,700	1.30	1.30
1982	32,400	1.30	1.30
Changes scheduled in present law:			
1983-84	Subject to	1.30	1.30
1985	automatic	1.35	1.35
1986 & later	increase.	1.45	1.45

SUMMARY OF THE OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1981

A statement of the incomes and disbursements of the Federal Hospital Insurance Trust Fund in fiscal year 1981, and of the assets of the fund at the beginning and end of the fiscal year, is presented in table 2. Corresponding amounts for fiscal year 1980 are also shown in the table.

The total assets of the trust fund amounted to $14,490 million on September 30, 1980. During fiscal year 1981, total receipts amount to $32,863 million, and total disbursements were $29,260 million. The assets of the trust fund thus increased $3,603 million during the year to a total of $18,093 million on September 30, 1981.

Included in total receipts during fiscal year 1981 were $27,482 million representing contributions appropriated to the trust fund and $3,032 million representing amounts received in accordance with State agreements for coverage of state and local government employees and deposited in the trust fund. As an offset, $89 million was transferred from the trust fund into the Treasury as repayment for the estimated amount of contributions subject to refund to employees who worked for more than one employer during the course of a year and paid contributions on wages in excess of the statutory maximum earnings base.

Net contributions amounted to $30,425 million, representing an increase of 30.9 percent over the amount of $23,244 million for the preceding 12-month period. This growth in contribution income resulted

primarily from (1) the higher level of earnings in covered employment; (2) the two increases in the maximum annual amount of earnings taxable--from $22,900 to $25,900 and from $25,900 to $29,700--that became effective on January 1, 1980, and January 1, 1981, respectively, and (3) the increase in the combined tax rate from 2.1 percent to 2.6 percent--that became effective January 1, 1981.

The section entitled "Nature of the Trust Fund" referred to provisions of the Social Security Act under which certain persons aged 65 and over but not otherwise eligible for hospital insurance protection may obtain such protection by enrolling in the program and paying a monthly premium. Premiums collected from such voluntary participants in fiscal year 1981 amounted to about $20.8 million.

In accordance with the provisions of the Railroad Retirement Act which coordinate the railroad retirement and the hospital insurance programs and which govern the financial interchange arising from the allocation of costs between the two systems, the Railroad Retirement Board and the Secretary of Health and Human Services determined that a transfer of $246,700,000 from the railroad retirement account to the hospital insurance trust fund would place this fund in the same position, as of September 30, 1980, in which it would have been if railroad employment had always been covered under the Social Security Act. This amount, together with interest to the date of transfer amounting to $29,768,000, was transferred to the trust fund in June 1981.

In accordance with provisions for annual reimbursement from the general fund of the Treasury for the cost of granting noncontributory wage credits for military service, the Secretary of Health, Education, and Welfare determined in 1975 the level annual appropriation necessary to amortize the estimated total additional costs for military service prior to 1957. This cost is amortized over a 39-year period, which began in fiscal year 1977, with an allowance for the appropriations which were made for fiscal years 1966-76. The annual amount resulting from this determination was $141 million.

Again, the section entitled "Nature of the Trust Fund" referred to provisions under which the hospital insurance trust fund is to be reimbursed from the general fund of the Treasury for costs of paying benefits under this program on behalf of certain uninsured persons. The reimbursement in fiscal year 1981 amounted to $659 million, consisting of $652 million for benefit payments, $12 million for administrative expenses, and, as an offset, $5 million due from the trust fund to the general fund of the Treasury for interest on adjustments to costs in prior fiscal years.

The section entitled "Nature of the Trust Fund" referred to provisions under which the hospital insurance trust fund is to be reimbursed from the general fund of the Treasury for the costs of reviewing hospital admissions under the Medicaid and Maternal and Child Health programs by Professional Standards Review Organizations. The reimbursement in fiscal year 1981 amounted to $34 million.

The remaining $1,307 million of receipts consisted almost entirely of interest on the investments of the trust fund.

Of the $29,260 million in total disbursements, $28,913 million represented benefits paid directly from the trust fund for health services covered under title XVIII of the Social Security Act. As offsets to benefit payments, transfers were made from the supplementary medical insurance trust fund amounting to $6 million to adjust for the loss of interest caused by the delay in transferring payments for the costs of radiology and pathology services that were paid initially from the hospital insurance trust fund but that were liabilities of the supplementary medical insurance trust fund. Net benefit payments from the trust fund in fiscal year 1981, therefore, amounted to $28,907 million, an increase of 21.5 percent over the corresponding amount of $23,790 million paid during the preceding 12 months. An additional $2 million in disbursements constituted payment for costs of experiments and demonstration projects in providing health care services.

The remaining $351 million of disbursements was for net administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds--old-age and survivors insurance, disability insurance, hospital insurance, and supplementary medical insurance--on the basis of provisional estimates. Similarly, the expenses of administering other programs of the Health Care Financing Administration are also allocated and charged directly to the general fund of the Treasury on a provisional basis. Periodically, as actual experience

develops and is analyzed, adjustments to the allocations of administrative expenses and costs of construction for prior periods are effected by interfund transfers, including transfers between the hospital insurance and supplementary medical insurance trust funds and the program management general fund account, with appropriate interest allowances.

Table 3 compares the actual experience in fiscal year 1981 with the estimates presented in the 1980 and 1981 annual reports. The section entitled "Nature of the Trust Fund" referred to the appropriation of contributions to the trust funds on an estimated basis, with subsequent periodic adjustments to account for differences from the amounts of contributions actually payable on the basis of reported earnings. In interpreting the figures in table 3, it should be noted that the "actual" amount of contributions in fiscal year 1981 reflects the aforementioned type of adjustments to contributions for prior fiscal years. On the other hand, the "actual" amount of contributions in fiscal year 1981 does not reflect adjustments to contributions for fiscal year 1981 that were to be made after September 30, 1981.

The assets of the hosital insurance trust fund at the end of fiscal year 1980 totaled $14,490 million, consisting of $14,656 million in the form of obligations of the U.S. Government or of federally-sponsored agency obligations and as an offset, an extension of credit of $166 million against securities to be redeemed. The assets of the hospital insurance trust fund at the end of fiscal year 1981 totaled $18,093 million, consisting of $18,191 million in the form of

obligations of the U.S. Government or of federally-sponsored agency obligations and as an offset, an extension of credit of $99 million against securities to be redeemed. This was covered by the redemption of securities early in October 1981. Table 4 shows the total assets of the fund and their distribution at the end of fiscal years 1980 and 1981.

The net increase in the par value of the investments held by the fund during fiscal year 1980 amounted to $1,493 million. New securities at a total par value of $27,784 million were acquired during the fiscal year through the investment of receipts and the reinvestment of funds made available from the redemption of securities. The par value of securities redeemed during the fiscal year was $26,292 million. Included in these amounts are $24,905 million in certificates of indebtedness that were acquired and $24,803 million in certificates of indebtedness that were redeemed during the fiscal year.

The net increase in the par value of the investments held by the fund during fiscal year 1981 amounted to $3,535 million. New securities at a total par value of $37,147 million were acquired during the fiscal year through the investment of receipts and the reinvestment of funds made available from the redemption of securities. The par value of securities redeemed during the fiscal year was $33,611 million. Included in these amounts are $32,458 million in certificates of indebtedness that were acquired and $32,060 million in certificates of indebtedness that were redeemed within the fiscal year.

The effective annual rate of interest earned by the assets of the hospital insurance trust fund during the 12 months ending on June 30, 1981, was 8.9 percent. (This period is used because interest on special issues is paid semiannually on June 30 and December 31.) The interest rate on public-debt obligations issued for purchase by the trust fund in June 1981 was 13 percent, payable semiannually.

TABLE 2.--STATEMENT OF OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING FISCAL YEARS 1980 AND 1981

(In thousands of dollars)

	Fiscal Year 1980	Fiscal Year 1981
Total assets of the trust fund, beginning of period	$13,362,700	$14,489,913
Receipts:		
Contributions:		
Appropriations	$20,735,922	$27,482,186
Deposits arising from State agreements	2,595,087	3,031,534
Gross Contributions	23,331,009	30,513,721
Less payment into the Treasury for contributions subject to refund	87,240	88,500
Net contributions	23,243,769	30,425,221
Premiums collected from voluntary participants	16,566	20,759
Transfer from railroad retirement account	244,280	276,468
Reimbursement from general fund of Treasury for costs of--		
Noncontributory credits for military service	141,000	141,000
Benefits for uninsured persons:		
Benefit payments	678,425	652,384
Administrative expenses	12,000	11,900
Interest on adjustments to costs in prior fiscal years	6,481	-5,284
Total reimbursement for costs for benefits for uninsured persons	696,906	659,000
Review of Medicaid, and Maternal and Child Health hospital admissions	33,250	33,600
Interest:		
Interest on investments	1,039,925	1,271,713
Interest on amounts of interfund transfers 1/	-972	35,566
Total interest	1,038,953	1,307,279
Total receipts	$25,414,724	$32,863,326
Disbursements:		
Benefit payments:		
Paid directly from the trust fund for the costs of health services	23,796,365	28,913,417
Less transfers from the supplementary medical insurance trust fund for reimbursement of interest loss related to transfer payments made in conjunction with the costs of radiology and pathology services 2/	6,000	6,000
Net benefit payments	23,790,365	28,907,417
Costs of experiments and demonstration projects 2/	3,034	1,664
Administrative expenses:		
Department of Health and Human Services 3/	478,889	551,291
Treasury Department	2,813	7,437
Construction of facilities	2,404	339
Gross administrative expenses	484,106	559,067
Interfund transfers due to reimbursement of:		
Social Security Administration expenses 4/	10,014	7,326
Health Care Financing Administration expenses 4/	0	-215,154
Less receipts from sale of supplies, materials, etc	29	11
Net administrative expenses	494,091	351,229
Total disbursements	24,287,511	29,260,310
Net addition to the trust fund	1,127,213	3,603,016
Total assets of the trust fund, end of period	$14,489,913	$18,092,929

1/ A positive figure represents a transfer of interest to the hospital insurance trust fund from the other trust funds. A negative figure represents a transfer of interest from the hospital insurance trust fund to the other trust funds.

2/ For explanation, see text.

3/ Includes administrative expenses of the intermediaries.

4/ A positive figure represents a transfer from the hospital insurance trust fund to the other trust funds. A negative figure represents a transfer to the hospital insurance trust fund from the other trust funds.

NOTE: Totals do not necessarily equal the sum of rounded components.

TABLE 3.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, FISCAL YEAR 1981
(Dollar amounts in millions)

Item	Actual Amount	Comparison of actual experience with estimates for fiscal year 1981 published in-- 1981 Report: Estimated Amount	1981 Report: Actual as percentage of estimate	1980 Report: Estimated Amount	1980 Report: Actual as percentage of estimate
Net contributions	$30,425	$30,242	101	$30,019	101
Benefit payments	$28,907	$28,171 1/	103	$26,862	108

1/ Includes an adjustment of $515 million due to the temporary delay in the Periodic Interim Payment method of reimbursement provision provided for by "The Omnibus Reconciliation Act of 1980" (P.L. 96-497). This provision was repealed by "The Omnibus Reconciliation Act of 1981" (P.L. 97-35).

TABLE 6.--ASSETS OF THE HOSPITAL INSURANCE TRUST FUND BY TYPE AT THE END OF FISCAL YEARS 1980 and 1981 1/

	September 30, 1980	September 30, 1981
Investments in public-debt obligations sold only to this fund (special issues):		
Certificates of indebtedness:		
11 1/8-percent, 1981	$ 1,273,417,000.00	
16 7/8-percent, 1982		$ 1,673,217,000.00
Bonds:		
7 1/8-percent, 1992	334,479,000.00	334,479,000.00
7 3/8-percent, 1993	183,760,000.00	132,135,000.00
7 3/8-percent, 1994	183,760,000.00	183,760,000.00
7 3/8-percent, 1995	183,759,000.00	183,759,000.00
7 3/8-percent, 1996	183,759,000.00	183,759,000.00
7 3/8-percent, 1997	183,759,000.00	183,759,000.00
7 3/8-percent, 1998	183,760,000.00	183,760,000.00
7 3/8-percent, 1999	183,760,000.00	183,760,000.00
7 3/8-percent, 2000	371,444,000.00	371,444,000.00
7 1/2-percent, 1923	189,372,000.00	189,372,000.00
7 1/2-percent, 1924	189,372,000.00	189,372,000.00
7 1/2-percent, 1925	189,373,000.00	189,373,000.00
7 1/2-percent, 1926	189,373,000.00	189,373,000.00
7 1/2-percent, 1927	189,373,000.00	189,373,000.00
7 1/2-percent, 1928	189,372,000.00	189,372,000.00
7 1/2-percent, 1929	189,372,000.00	189,372,000.00
7 1/2-percent, 1930	189,373,000.00	189,372,000.00
7 1/2-percent, 1931	480,816,000.00	480,816,000.00
7 3/8 percent, 1932	296,097,000.00	
7 3/8-percent, 1937	465,665,000.00	465,665,000.00
7 3/8-percent, 1938	465,665,000.00	465,665,000.00
7 3/8-percent, 1939	465,665,000.00	465,665,000.00
7 3/8-percent, 1940	465,665,000.00	465,665,000.00
7 3/8-percent, 1941	465,665,000.00	465,665,000.00
7 3/8-percent, 1942	465,664,000.00	465,664,000.00
7 3/8-percent, 1943	465,664,000.00	465,664,000.00
8 1/8-percent, 1962	43,347,000.00	
8 1/8-percent, 1963	43,347,000.00	43,347,000.00
8 1/8-percent, 1964	43,347,000.00	43,347,000.00
8 1/8-percent, 1965	43,347,000.00	43,347,000.00
8 1/8-percent, 1966	43,346,000.00	43,346,000.00
8 1/8-percent, 1967	43,346,000.00	43,346,000.00
8 1/8-percent, 1968	43,347,000.00	43,347,000.00
8 1/8-percent, 1969	43,347,000.00	43,347,000.00
8 1/8-percent, 1970	43,347,000.00	43,347,000.00
8 1/8-percent, 1971	43,347,000.00	43,347,000.00
8 1/8-percent, 1972	43,347,000.00	43,347,000.00
8 1/8-percent, 1973	281,664,000.00	281,664,000.00
8 3/8-percent, 1982	726,163,000.00	726,163,000.00
8 3/8-percent, 1983	123,797,000.00	
8 3/8-percent, 1984	123,797,000.00	123,797,000.00
8 3/8-percent, 1985	123,797,000.00	123,797,000.00
8 3/8-percent, 1986	123,797,000.00	123,797,000.00
8 3/8-percent, 1987	123,797,000.00	123,797,000.00
8 3/8-percent, 1988	123,797,000.00	123,797,000.00
8 3/8-percent, 1989	123,797,000.00	123,797,000.00
8 3/8-percent, 1990	123,797,000.00	123,797,000.00
8 3/8-percent, 1991	123,797,000.00	123,797,000.00
8 3/8-percent, 1992	123,797,000.00	123,797,000.00
8 3/8-percent, 1993	123,797,000.00	123,797,000.00
8 3/8-percent, 1994	849,440,000.00	849,440,000.00
9 3/8-percent, 1982	130,210,000.00	
9 3/8-percent, 1983	130,399,000.00	130,399,000.00
9 3/8-percent, 1984	130,399,000.00	130,399,000.00
9 3/8-percent, 1985	130,399,000.00	130,399,000.00
9 3/8-percent, 1986	130,210,000.00	130,210,000.00
9 3/8-percent, 1987	130,210,000.00	130,210,000.00
9 3/8-percent, 1988	130,210,000.00	130,210,000.00
9 3/8-percent, 1989	130,210,000.00	130,210,000.00
9 3/8-percent, 1990	130,210,000.00	130,210,000.00
9 3/8-percent, 1991	130,210,000.00	130,210,000.00
9 3/8-percent, 1992	130,210,000.00	130,210,000.00
9 3/8-percent, 1993	130,210,000.00	130,210,000.00
9 3/8-percent, 1994	130,210,000.00	130,210,000.00
9 3/8-percent, 1995	979,678,000.00	979,678,000.00
13 -percent, 1982		197,607,000.00
13 -percent, 1984		197,607,000.00
13 -percent, 1985		197,607,000.00
13 -percent, 1986		197,606,000.00
13 -percent, 1987		197,606,000.00
13 -percent, 1988		197,606,000.00
13 -percent, 1989		197,606,000.00
13 -percent, 1990		197,606,000.00
13 -percent, 1991		197,606,000.00
13 -percent, 1992		197,606,000.00
13 -percent, 1993		197,606,000.00
13 -percent, 1994		197,606,000.00
13 -percent, 1995		197,606,000.00
13 -percent, 1996		197,606,000.00
Total public-debt obligations sold only to this fund (special issues)	$18,089,977,000.00	$18,161,479,000.00
Investments in federally-sponsored agency obligations:		
Participation certificates:		
Federal Assets Liquidation Trust:		
Government National Mortgage Association:		
3.50-percent, 1990	50,000,000.00	50,000,000.00
Total investments	$18,139,977,000.00	$18,191,479,000.00
Unobligated balance	-146,163,000.03 2/	-60,340,787.63 2/
Total assets	$18,689,913,999.97	$18,078,979,212.37

1/ The assets are carried at par value, which is the same as book value.

2/ The negative figure represents an extension of credit which was covered by redemption of securities on the first day of the following month.

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EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND DURING THE PERIOD OCTOBER 1, 1981 TO DECEMBER 31, 1984

The expected operations of the trust fund during fiscal years 1982-84 are shown in table 5, together with the past experience of the program. The projection shown in table 5—and the entirety of this section—is based on two intermediate sets of projection assumptions labeled alternative II-A and alternative II-B, which are presented in detail in Appendix A. The economic assumptions underlying these two alternative sets of assumptions are described in detail in the 1982 Annual Report of the Board of Trustees of the Federal Old Age and Survivors Insurance and Disability Insurance Trust Funds.

The estimates of income from hospital insurance contributions are at a considerably higher level during the period projected than during the past. This occurs primarily as a result of the increase in the hospital insurance tax rate which took place on January 1, 1981, and the higher earnings bases scheduled in the law.

Income received through the financial interchange between the railroad retirement account and the trust fund under the provisions of the Railroad Retirement Act is estimated on the same basis as income from hospital insurance contributions. Estimates of the corresponding outgo are included in the disbursement items.

Estimated income to the trust fund which is appropriated from general revenues to reimburse the program for the cost of coverage of noninsured persons is the same as the estimates of disbursements for such persons, net

of corrections for differences between costs and amounts transferred for previous years. Premium income and disbursements for other noninsured persons over age 65 who may enroll in the hospital insurance program on a voluntary basis are based on an estimated enrollment of 22,000 in fiscal year 1982.

Reimbursement from general revenues for military wage credits is projected at $207 million for fiscal year 1982 and after. This is based on the determination made by the Secretary of Health and Human Services in 1980 of the level annual appropriations necessary to amortize the additional costs arising from these wage credits.

Estimated reimbursement from general revenues for the cost, paid initially from the hospital insurance trust fund, of Professional Standard Review Organization (PSRO) review of hospital admissions under Federal programs other than the hospital insurance program is based on estimates of the payments for such reviews, net of corrections for differences between payments and amounts transferred in previous years. Beginning in fiscal year 1982, in accordance with provisions of "The Omnibus Reconciliation Act of 1981" (P.L. 97-35), the hospital insurance trust fund will no longer pay for PSRO review of hospital admissions for Federal programs other than the hospital insurance program.

The investment of new assets received during fiscal years 1982-84 is assumed to be in the form of special public-debt obligations bearing interest rates ranging from 13 5/8 percent, payable semiannually in 1982,

to 9 3/4 percent in 1984. The average effective annual rate of interest on the assets held by the hospital insurance trust fund on September 30, 1980, was 10.1 percent.

The total income for fiscal year 1983 and calendar year 1982 in table 5 and 6, respectively, is reduced by the amounts to be loaned on December 31, 1982, by the hospital insurance trust fund under the interfund borrowing provisions of P.L. 97-123. The amounts to be loaned are $779 million and $5,313 million under alternative II-A and II-B, respectively.

Disbursements for benefits are projected to increase sharply in fiscal years 1982-84, primarily as a result of the high rate of increase in hospital costs reimbursable under the program. The expenditures for benefit payments shown in table 5 differ slightly from those shown in the 1983 Federal budget. These estimates are based on more recent demographic and economic projections, and they do not reflect the implementation of proposed changes in regulations which were included in the budget.

The actual operation of the hospital insurance program is organized, in general, on a calendar year basis. Earnings subject to taxation and the applicable tax rates are established by calendar year, as are the inpatient deductible and other cost sharing amounts. The projected operations of the trust fund on a calendar year basis are shown in table 6, according to the same assumptions as used in table 5. The ratios of assets in the trust fund at the beginning of each calendar year to total disbursements during that year are shown in table 7 for past years and as projected through 1984.

TABLE 7.—RATIO OF ASSETS IN THE FUND AT THE BEGINNING OF THE YEAR TO DISBURSEMENTS DURING THE YEAR FOR THE HOSPITAL INSURANCE TRUST FUND
(In percent)

Calendar Year	Ratio
Historical Data:	
1967	28%
1968	25
1969	43
1970	47
1971	54
1972	47
1973	40
1974	69
1975	79
1976	77
1977	66
1978	57
1979	54
1980	52
1981	45
Projection:	
Alternative II-A	
1982	53
1983	52
1984	49
Alternative II-B	
1982	53
1983	38
1984	34

ACTUARIAL STATUS OF THE TRUST FUND

The Board of Trustees has adopted the general financing principle that annual income to the hospital insurance program should be approximately equal to annual outlays of the program plus an amount to maintain a balance in the trust fund equal to one-half year's expenditures. This principle reflects the view that a small fund is needed for the contingency that future income and outgo may differ substantially from projected levels, but that it is unnecessary and impractical to fund fully the future benefits of workers as they accrue the right to those future benefits.

The projected expenditures under the program, expressed as percentages of taxable payroll, are summarized for selected years over the next 25-year period in table 8. The ratio of expenditures to taxable payroll has increased from 0.95 percent in 1967 to 2.39 percent in 1981, reflecting both the higher rate of increase in hospital costs than in earnings subject to hospital insurance taxes and the extension of hospital insurance benefits to disabled beneficiaries and persons suffering from end-stage renal disease. Further increases in this ratio to 2.94 percent in 1985, and 6.18 percent by the year 2005 under alternative II-A, and 3.06 percent in 1985 and 7.03 percent by the year 2005 under alternative II-B, result from the assumption that the cost of institutional health care will continue to increase at a higher rate than taxable earnings. (See appendix A for a description of the methodology and assumptions used in these projections.)

The allowances necessary to build the trust fund to the level of a half year's disbursements and to maintain it at that level, after accounting for the offsetting effect of interest earnings, are also shown in table 8.

The tax rates scheduled in the law are sufficient to maintain the trust fund at the level of a half year's disbursements only through 1983 under alternative II-A. Under alternative II-B the trust fund is projected to decline immediately below the desired level. Additional financing will be required beginning early in the 1980's to maintain the trust fund at the level of a half year's disbursements. For purposes of display in table 8, the allowance for trust fund building and maintenance is solely for maintaining the trust fund at the 50 percent level throughout the 25-year projection period. In table 8 the interfund loan to the old age and survivor insurance trust fund in calendar year 1982 is reflected in the calendar year 1982 cost under alternative II-A. The loan is assumed to be repaid with interest during the 25-year projection period and, therefore, will have no effect on the 25-year average cost. However, under alternative II-B, the loan is assumed not to be repaid, and hence is reflected in both the calendar year 1982 cost and the 25-year average cost.

The adequacy of the financing of the hospital insurance program under current law is measured by comparing on a year-by-year basis the actual tax rates specified by law with the corresponding total costs of the program, expressed as percentages of taxable payroll. If these two items are exactly equal in each year of the 25-year projection period and all projections assumptions are realized, tax revenues along with interest income will be sufficient to provide for benefits and administrative expenses for insured persons and to maintain the trust fund at the 50 percent level. In practice, however, tax rate schedules generally are designed with rate changes occurring only at intervals of several years, rather than with continual yearly increases to match exactly with projected cost increases. To the extent that small

differences between the yearly costs of the program and the corresponding tax rates occur for short periods of time and are offset by subsequent differences in the reverse direction, the substance of the financing objectives will have been met.

The projected total costs of the program under alternatives II-A and II-B expressed as percentages of taxable payroll, and the tax rates scheduled under current law are shown in table 8 for selected years over the 25-year period 1982-2006. The total cost of the program including expenditures, the loan to the old-age and survivors insurance trust fund, plus trust fund building and maintenance, exceeds the tax rate in every year in both projections. Furthermore, expenditures for benefits and administrative expenses alone exceed the corresponding tax rates for all years with the exception of 1982 under alternative II-A. The trust fund as a percent of a year's disbursements is projected to decrease slightly to a level of about 52 percent in 1983 under alternative II-A assumptions and then to decline steadily thereafter until it is completely exhausted in about 1989. Under alternative II-B the trust fund is projected to decline steadily until it is completely exhausted in 1987.

The actuarial balance of the hospital insurance program is defined to be the excess of the average tax rate for the 25-year valuation period over the average cost of the program, expressed as a percent of taxable payroll, for the same period. The average tax rate for the 25-year period 1982-2006 is 2.66 percent. The average cost to the program under alternative II-A is 4.49 percent of taxable payroll, composed of 4.40 percent for program expenditures and .09 percent for maintenance of the trust fund. The average cost of the program under alternative II-B is 4.93 percent of taxable payroll, composed of 4.83 percent for program expenditures and .10 percent

TABLE 5.--OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING FISCAL YEARS 1967-84
(In millions)

	Income								Disbursements			Trust Fund	
Fiscal Year 1/	Payroll taxes	Transfers from railroad retirement account	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Reimbursement for military wage credits	Reimbursement for PSRO review	Interest on investments	Total income	Benefits payments	Administrative expenses2/	Total disbursements	Net increase in fund	Fund at end of year
Historical Data:													
1967	$ 2,689	$ 16	$327		$ 11		$ 46	$ 3,089	$ 2,508	$ 89	$ 2,597	$ 492	$ 1,343
1968	3,514	44	273		11		61	3,902	3,736	79	3,815	88	1,431
1969	4,423	54	749		22		96	5,344	4,654	104	4,758	586	2,017
1970	4,785	64	617		11		137	5,614	4,804	149	4,953	661	2,677
1971	4,898	66	863		11		180	6,018	5,442	150	5,592	426	3,103
1972	5,226	66	503		48		188	6,031	6,108	167	6,276	-245	2,859
1973	7,663	63	381		48		196	8,352	6,648	194	6,842	1,510	4,369
1974	10,602	99	451	$ 4	48		405	11,610	7,806	259	8,065	3,545	7,914
1975	11,291	132	481	6	48		609	12,568	10,353	259	10,612	1,956	9,870
1976	12,031	138	610	8	48		709	13,544	12,267	312	12,579	966	10,836
T.Q.	3,366	143	0 3/	2	0		5	3,516	3,315	89	3,404	112	10,948
1977	13,649	0 4/	803 3/	11	141		770	15,374	14,906	301	15,207	167	11,115
1978	16,677	214 4/	688	12	143 5/	$29	780	18,543	17,411	451	17,862	681	11,796
1979	19,927	191	734	17	141	33	868	21,910	19,891	452	20,343	1,567	13,363
1980	23,244	244	697	17	141	33	1,039	25,415	23,790	497	24,288	1,127	14,490
1981	30,425	276	659	21	141	34	1,307	32,863	28,907	353	29,260	3,603	18,093
Projection:													
Alternative II-A													
1982	34,992	344	800	25	207	0	1,901	38,277	33,788	564	34,352	3,925	22,018
1983	38,174	382	889	32	207	0	2,347	41,252 6/	39,050	605	39,655	1,597	23,615
1984	41,476	398	770	39	207	0	2,635	45,525	44,486	647	45,133	392	24,007
Alternative II-B													
1982	34,359	344	808	25	207	0	1,881	37,624	33,788	564	34,352	3,272	21,365
1983	37,590	375	889	32	207	0	2,270	36,050 6/	39,445	613	40,058	-4,008	17,357
1984	41,605	392	795	39	207	0	2,402	45,440	45,828	670	46,498	-1,058	16,299

1/ For 1967 through 1976, fiscal years cover the interval from July 1 through June 30; the three-month interval from July 1, 1976, through September 30, 1976, is labeled "T.Q.," the transition quarter; fiscal years 1977-84 cover the interval from October 1 through September 30.

2/ Includes costs of experiments and demonstration projects.

3/ The 1977 transfer is for benefits and administrative expenses during the five-quarter period covering the transition quarter and fiscal year 1977.

4/ The 1978 transfer is for contributions during the five-quarter period covering the transition quarter and fiscal year 1977.

5/ Includes $2 million in reimbursement from general revenues for costs arising from the granting of noncontributory wage credits to persons of Japanese ancestry who were interned during World War II.

6/ Total income for 1983 is reduced by amounts assumed to be loaned on December 31, 1982, by the HI Trust Fund under the interfund borrowing provisions. These amounts are $779 million and $5,313 million under alternatives II-A and II-B, respectively.

TABLE 6.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1966-84
(In millions)

Calendar Year	Income								Disbursements			Trust Fund	
	Payroll taxes	Transfers from railroad retirement account	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Reimbursement for military wage credits	Reimbursement for PSRO review	Interest on investments	Total income	Benefits payments	Administrative expenses1/	Total disbursements	Net increase in fund	Fund at end of year
Historical Data:													
1966	$ 1,858	$ 16	$ 26		$ 11		$ 32	$ 1,943	$ 891	$108	$ 999	$ 944	$ 944
1967	3,152	44	301		11		51	3,559	3,353	77	3,430	129	1,073
1968	4,116	54	1,022		22		74	5,287	4,179	99	4,277	1,010	2,083
1969	4,473	64	617		11		113	5,279	4,739	118	4,857	422	2,505
1970	4,881	66	863		11		158	5,979	5,124	157	5,281	698	3,202
1971	4,921	66	503		48		193	5,732	5,751	150	5,900	-168	3,034
1972	5,731	63	381		48		180	6,403	6,318	185	6,503	-99	2,935
1973	9,944	99	451	$ 2	48		278	10,821	7,057	232	7,289	3,532	6,467
1974	10,844	132	471	5	48		523	12,024	9,099	272	9,372	2,652	9,119
1975	11,502	138	621	7	48		664	12,980	11,315	266	11,581	1,399	10,517
1976	12,727	143	0 2/	9	141		746	13,766	13,340	339	13,679	88	10,605
1977	14,114	0 3/	803 2/	12	143 4/		784	15,856	15,737	283	16,019	-163	10,442
1978	17,324	214 3/	688	13	141	$29	805	19,213	17,682	496	18,178	1,035	11,477
1979	20,768	191	734	16	141	33	942	22,825	20,623	450	21,073	1,751	13,228
1980	23,848	244	697	18	141	33	1,116	26,097	25,064	512	25,577	521	13,749
1981	32,959	276	639	22	207	34	1,569	35,725	30,342	384	30,726	4,999	18,748
Projection:													
Alternative II-A													
1982	35,474	344	808	27	207	0	2,058	38,139 5/	35,097	573	35,670	2,469	21,217
1983	38,904	382	889	34	207	0	2,408	42,824	40,439	616	41,055	1,769	22,986
1984	42,285	398	770	40	207	0	2,539	46,239	45,951	657	46,608	-369	22,617
Alternative II-B													
1982	34,702	344	808	27	207	0	2,022	32,797 5/	35,097	573	35,670	-2,873	15,875
1983	38,463	375	889	34	207	0	2,269	42,237	40,995	627	41,622	615	16,490
1984	42,476	392	795	40	207	0	2,235	46,145	47,587	685	48,272	-2,127	14,363

1/ Includes costs of experiments and demonstration projects.

2/ No transfer is made in 1976 because of the change in transfer dates from December to March. The 1977 transfer is for benefits and administrative expenses during the 15-month period beginning July 1976 and ending September 1977.

3/ No transfer is made in 1977 because of the change in transfer dates from August to June. The 1978 transfer is for contributions during the five-quarter period covering the transition quarter and fiscal year 1977.

4/ Includes $2 million in reimbursement form general revenues for costs arising from the granting of noncontributory wage credits to persons of Japanese ancestry who were interned during World War II.

5/ Total income for 1982 is reduced by the amounts assumed to be loaned on December 31, 1982, by the HI Trust Fund under the interfund borrowing provisions. These amounts are $779 million and $5,313 million under alternatives II-A and II-B, respectively.

for maintenance of the trust fund. The resulting actuarial balances, as shown in table 9, are a deficit of 1.63 percent and 2.07 percent of taxable payroll for alternatives II-A and II-B, respectively.

Long-range cost estimates for the hospital insurance program have been made, since the beginning of the program, for the 25-year period beginning with the year of the report. A relatively long valuation period, such as 25 years, is necessary in order to depict the pattern of rising costs which will ensue if trends over the past two decades continue into the future. Even a valuation period as long as 25 years fails to present fully the future contingencies that reasonably may be expected, such as the impact of the demographic shift after the turn of the century which is discussed in the old-age, survivors, and disability insurance report. On the other hand, the degree of uncertainty concerning future hospital costs, relative to the remainder of the economy, is sufficiently great as to limit the usefulness of projections beyond 25 years. A precise prediction of the future is not possible, even in the short range; however, both short- and long-range estimates can be made, based on reasonable assumptions, which will indicate the trend and general range of future costs.

Since future economic, demographic, and health care usage and cost experience may differ considerably from either set of intermediate assumptions on which the cost estimates were based, projections also have been prepared on the basis of two alternative sets of assumptions. The estimated operations of the hospital insurance trust fund during calendar years 1981-91 are summarized in table 10 for all four alternatives, and table 11 compares the actuarial balance under each of the four. The assumptions underlying

alternatives II-A and II-B, the intermediate projections, are presented in substantial detail in appendix A. The assumptions used in preparing alternative projections I and III are also summarized in appendix A. The projections shown in the statement of expected operations and status of the trust fund through December 31, 1984, contained earlier in this report, are based on the assumptions contained in alternative II-A and II-B.

The four alternative sets of assumptions were selected in order to indicate the general range in which the cost of the program reasonably might be expected to fall. The alternative I assumptions are somewhat more optimistic than both alternative II assumptions, resulting in a lower average cost over the 25-year period and a stronger trust fund development. Alternatives I and III provide for a fairly wide range of possible experience. Actual experience reasonably may be expected to fall within the range, but no guarantee can be made that this will be the case, particularly in light of the wide variations in experience that have occurred since the beginning of the program. The projected trust fund development under alternative III also provides a measure of the strength of the financing of the program. An adequate financing schedule ought to be sufficiently strong to withstand, for a period of several consecutive years, conditions in the general economy and in the hospital sector which are substantially more adverse than anticipated under either alternative II-A or alternative II-B.

Under alternative II-A and alternative II-B, the trust fund as a percent of a year's disbursements is projected to decline steadily until it is completely exhausted in about 1989 and 1987, respectively. Under alternative I, the

trust fund is projected to grow slowly until about 1987, then to decline steadily until the fund is completely exhausted in 1991. Under alternative III, the trust fund as a percent of year's disbursements is projected to decrease with complete exhaustion of the fund by 1986. These projections do not reflect any reduction in disbursements due to proposed changes in regulations which were included in the 1983 Federal budget but which have not been implemented.

The divergence in outcomes among the four alternatives is reflected both in the estimated operations of the trust fund and in the 25-year average costs. The variations in the underlying assumptions, as shown in appendix A, can be characterized as (1) moderate in terms of magnitude of the differences on a year-by-year basis and (2) persistent over the duration of the 25-year period. Under both sets of intermediate assumptions, program costs are projected to grow at a rate which gradually declines to an ultimate level of approximately 3 percent more rapidly than taxable payroll. Under alternative I, program costs are projected to grow at a somewhat lower rate which gradually declines to an ultimate difference of 1.2 percent. Similarly, alternative III follows a pattern whereby program costs initially increase at a somewhat higher rate, gradually declining to an ultimate difference of about 5.4 percent. Recent experience has indicated that economic conditions producing results as adverse as those under alternative III can occur. In view of this and because of the wide range of possible experience, it is important that a substantial balance be maintained in the hospital insurance trust fund as a reserve for contingencies.

TABLE 8.—COST AND TAX RATES OF THE HOSPITAL INSURANCE PROGRAM, EXPRESSED AS A PERCENT OF TAXABLE PAYROLL

Calendar Year	Expenditures under the program 1/	Trust fund building and maintenance 2/	Total cost of the program	Tax rate scheduled in the law 3/	Difference
Historical Data:					
1967	0.95%				
1968	1.05				
1969	1.13				
1970	1.21				
1971	1.33				
1972	1.31				
1973	1.34				
1974	1.42				
1975	1.69				
1976	1.83				
1977	1.95				
1978	2.02				
1979	2.00				
1980	2.21				
1981	2.39				
Projection:					
Alternative II-A					
1982	2.60% 5/	0.09%	2.69%	2.60%	-0.09%
1983	2.68	0.09	2.77	2.60	-0.17
1984	2.80	0.09	2.89	2.60	-0.29
1985	2.94	0.09	3.03	2.70	-0.33
1990	3.68	0.09	3.77	2.90	-0.87
1995	4.59	0.09	4.68	2.90	-1.78
2000	5.40	0.09	5.49	2.90	-2.59
2005	6.18	0.09	6.27	2.90	-3.37
Average 4/	4.40	0.09	4.49	2.86	-1.63
Alternative II-B					
1982	2.98% 5/	0.10%	3.08%	2.60%	-0.48%
1983	2.75	0.10	2.85	2.60	-0.25
1984	2.90	0.10	3.00	2.60	-0.40
1985	3.06	0.10	3.16	2.70	-0.46
1990	3.93	0.10	4.03	2.90	-1.13
1995	5.00	0.10	5.10	2.90	-2.20
2000	6.01	0.10	6.11	2.90	-3.21
2005	7.03	0.10	7.13	2.90	-4.23
Average 4/	4.83	0.10	4.93	2.86	-2.07

1/ Costs attributable to insured beneficiaries only. Benefits and administrative costs for noninsured persons are financed through general revenue transfers and premium payments rather than through payroll taxes.

2/ Allowance for maintaining the trust fund balance at the level of a half year's outgo after accounting for the offsetting effect of interest earnings.

3/ Rates for employees and employers combined.

4/ Average for the 25-year period 1982-2006.

5/ Takes into account amounts to be loaned to the old-age and survivors insurance trust fund under the interfund borrowing provisions. The loan is assumed not repaid under alternative II-B; it is repaid in 1998 under alternative II-A.

NOTE: Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

TABLE 9.--ACTUARIAL BALANCE OF THE HOSPITAL INSURANCE PROGRAM, EXPRESSED AS A PERCENT OF TAXABLE PAYROLL

	Alternative II-A	Alternative II-B
Average contribution rate, scheduled under present law*	2.86%	2.86%
Average cost of the program:*		
Expenditures, for benefit payments and administrative costs for insured beneficiaries	4.40	4.83
Maintaining the trust fund, at the level of one-half year's expenditures	.09	.10
Total cost of the program	4.49	4.93
Actuarial balance	-1.63%	-2.07%

* Average for the 25-year period 1982-2006.

NOTE: Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiiple-employer "excess wages" as compared with the combined employer-employee rate.

TABLE 10.—ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1981-91, UNDER ALTERNATIVE SETS OF ASSUMPTIONS
(Dollar amounts in billions)

Calendar Year	Total Income	Total disbursements	Net increase in fund	Fund at end of year	Ratio of assets to disbursements 1/ (percent)
			ALTERNATIVE I		
1981 2/	$35.7	$30.7	$5.0	$18.7	45%
1982	37.9 3/	35.7	2.2	21.0	53
1983	43.3	41.2	2.1	23.1	51
1984	47.7	47.1	0.5	23.6	49
1985	53.7	53.5	0.2	23.8	44
1986	62.2	60.1	2.1	25.9	40
1987	67.3	67.1	0.2	26.1	39
1988	72.2	74.6	-2.4	23.8	35
1989	76.9	82.4	-5.5	18.2	29
1990	80.6	89.7	-9.1	9.2	20
1991	85.2	98.6	-13.4	4/	9
			ALTERNATIVE II-A		
1981 2/	35.7	30.7	5.0	18.7	45
1982	38.1 3/	35.7	2.5	21.2	53
1983	42.8	41.1	1.8	23.0	52
1984	46.2	46.6	-0.4	22.6	49
1985	51.9	53.3	-1.4	21.2	42
1986	60.0	60.8	-0.8	20.4	35
1987	65.2	69.1	-4.0	16.5	30
1988	70.1	78.6	-8.5	8.0	21
1989	74.7	88.5	-13.8	5/	9
			ALTERNATIVE II-B		
1981 2/	35.7	30.7	5.0	18.7	45
1982	32.8 3/	35.7	-2.9	15.9	53
1983	42.2	41.6	0.6	16.5	38
1984	46.1	48.3	-2.1	14.4	34
1985	51.5	55.6	-4.0	10.3	26
1986	59.3	63.4	-4.2	6.2	16
1987	63.7	72.1	-8.4	6/	9
			ALTERNATIVE III		
1981 2/	35.7	30.7	5.0	18.7	45
1982	31.3 3/	35.7	-4.4	14.4	53
1983	41.3	41.6	-0.3	14.1	35
1984	44.5	48.7	-4.1	9.9	29
1985	50.4	58.1	-7.7	2.3	17
1986	58.6	68.8	-10.1	7/	3

1/ Ratio of assets in the trust fund at the beginning of the year to disbursements during the year.

2/ Figures for 1981 represent actual experience.

3/ Total income for 1982 reflect amounts assumed to be loaned on December 31, 1982, by the HI trust fund under the interfund borrowing provisions. These amounts are $914 million, $779 million, $5,313 million, and $6,680 million under alternatives I, II-A, II-B, and III, respectively.

4/ Trust fund depleted in calendar year 1991.

5/ Trust fund depleted in calendar year 1989.

6/ Trust fund depleted in calendar year 1987.

7/ Trust fund depleted in calendar year 1986.

NOTE: Totals do not necessarily equal the sum of rounded components.

TABLE 11.—ACTUARIAL BALANCE OF THE HOSPITAL INSURANCE PROGRAM, UNDER ALTERNATIVE SETS OF ASSUMPTIONS

	Alternative			
	I	II-A	II-B	III
Average contribution rate, scheduled under present law 1/	2.86%	2.86%	2.86%	2.86%
Average cost of the program, for expenditures and for trust fund maintenance 2/	3.72	4.49	4.93	6.59
Actuarial balance	-0.86	-1.63	-2.07	-3.73

1/ Average for the 25-year period 1982-2006.

2/ Average for the 25-year period 1982-2006, expressed as a percent of taxable payroll.

NOTE: Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

CONCLUSION

The present financing schedule for the hospital insurance program is not adequate to provide for the expenditures anticipated over the entire 25-year valuation period if the assumptions underlying the estimates are realized. Tax rates currently specified in the law (including the scheduled increases in 1985 and 1986) are sufficient, along with interest earnings and assets in the fund, to support program expenditures and to make the required loans to the old-age and survivors insurance trust fund only over the next five to seven years. The financing for the remainder of the 25-year valuation period is not sufficient to provide for projected benefits and administrative expenses. The average tax rate necessary to provide for benefits and administrative expenses plus maintenance of the trust fund at the level of a half year's disbursements exceeds the average tax rate scheduled in the law, producing an average deficit of 1.63 percent of taxable payroll under alternative II-A and 2.07 percent under alternative II-B over the entire 25-year projection period. Even under the more optimistic alternative I assumptions, the present financing schedule will result in the fund being exhausted during the early 1990's.

The trust fund balance at the beginning of 1982 was at about the level of a half year's disbursements. The ratio of fund to disbursements is projected to decline through the 1980's until completely exhausted in 1989 and 1987 under alternative II-A and II-B, respectively. Under the less optimistic alternative III assumptions, the decline of the trust fund is accelerated, with complete exhaustion of the fund by 1986.

Although the hospital insurance trust fund is not in immediate danger of being unable to provide benefits which become payable, the present financing schedule is not adequate to ensure the payment of benefits even through the remainder of this decade. Disbursements exceed income in the near future leading to complete exhaustion of the fund in the latter half of the 1980's. The interfund loan to the old-age and survivors insurance trust fund will not be repaid in time to delay the time of exhaustion of the hospital insurance trust fund, thus further weakening the financial status of the hospital insurance trust fund. In order to bring the hospital insurance program into close actuarial balance, either disbursements of the program will have to be reduced or financing increased by more than one-third.

The National Commission on Social Security Reform established by the President will be addressing the financial status of the Social Security trust funds. The Commission's report is due by December 31, 1982. In addition, the Administration has recommended a package of legislative proposals intended to help curtail the rapid growth of the cost of the hospital insurance program. The Board recommends enactment of these proposals or of similar ones which will accomplish the same objective of curtailing the rapid growth of the hospital insurance program.

APPENDIX A

ACTUARIAL METHODOLOGY AND PRINCIPAL ASSUMPTIONS FOR THE HOSPITAL INSURANCE COST ESTIMATES*

The basic methodology and assumptions for alternative II-A and alternative II-B used in the estimates for the hospital insurance program are described in this appendix. These alternatives reflect two different levels of expectation of future performance of the economy. In addition, sensitivity testing of program costs under alternative sets of assumptions is presented.

1. PROGRAM COSTS

The principal steps involved in projecting the future costs of the hospital insurance program are (1) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base; (2) projecting increases in the cost of inpatient hospital services covered under the program; (3) projecting increases in the cost of skilled nursing facility and home health agency services covered under the program; and (4) projecting increases in administrative costs. The major emphasis will be directed toward the cost of inpatient hospital services, which accounts for approximately 95 percent of benefit expenditures.

a. Projection Base

The hospital insurance program is obligated by law, to reimburse institutional providers for the reasonable cost of providing covered services to beneficiaries. In order to establish a suitable base from which to project the future costs of the program, the incurred reasonable

* Prepared by the Division of Medicare Cost Estimates, Bureau of Data Management and Strategy, Health Care Financing Administration

cost of services provided must be reconstructed for the most recent period for which a reliable determination can be made. To do this, payments to providers must be attributed to dates of service, rather than to payment dates. In addition, the nonrecurring effects of any changes in regulations or administration of the program and of any items affecting only the timing and flow of payments to providers must be eliminated. As a result, the rates of increase in the incurred cost of the program differ from the increases in cash disbursement shown in tables 5 and 6.

The reasonable costs of covered services to beneficiaries are determined on the basis of provider cost reports. Payments to a provider initially are made on an "interim" basis; to adjust interim payments to the level of retroactively determined costs, a series of payments or recoveries is effected through the course of cost settlement with the provider. The net amounts paid to date to providers in the form of cost settlements are known; however, the incomplete data available do not permit a precise determination of the exact amounts incurred during specific periods of time. Due to the time required to obtain cost reports from providers, to verify these reports, and to perform audits (where appropriate), final settlements have lagged behind the liability for such payments or recoveries by as much as several years for some providers. Hence, the final cost of the program has not been completely determined for the most recent years of the program, and some degree of uncertainty remains even for earlier years.

Additional problems are posed by changes in administrative or reimbursement policy which have a substantial effect on either the amount or

incidence of payment. The extent and timing of the incorporation of such changes into interim payment rates and cost settlement amounts cannot be determined precisely.

The process of allocating the various types of payments made under the program to the proper incurred period--using incomplete data and estimates of the impact of administrative actions--presents difficult problems, the solution to which can be only approximate. Under the circumstances, the best that can be expected is that the actual incurred cost of the program for a recent period can be estimated within a few percent. This increases the error of projection directly, by incorporating any error in estimating the base year into all future years.

b. Hospital Costs

The hospital insurance program reimburses participating hospitals for the reasonable cost of providing covered services to beneficiaries. Because of its cost reimbursement nature, the program essentially pays for the share of aggregate inpatient hospital costs which is allocated to beneficiaries. Hence, for analysis and projection purposes, trends in program costs can be separated conceptually into (1) increases in aggregate expenditures by hospitals for all patients in producing services of the types covered by the program and (2) changes in the share of these expenditures that are for hospital insurance beneficiaries and hence will be paid by the hospital insurance program.

Increases in aggregate inpatient hospital costs can be analyzed into three broad categories:

(1) Economic factors--the increase in unit costs that would result if hospitals' input cost increases (wage increases for hospital employees and price increases for goods and services purchased by hospitals) were the same as those for the general economy;

(2) Volume of services--the increase in total output of units of service (as measured by hospital admissions); and

(3) Unit input intensity--the increase in total costs due to increased labor and nonlabor input intensity (wage and price increases for hospital inputs which are more rapid than for workers and products in the general economy, plus increases in the number of hospital employees and amount of supplies and equipment used to produce a unit of service).

It has been possible to isolate some of these elements and to identify their roles in previous hospital cost increases. Table A1 shows the values of the principal components of the increases for historical periods for which data are available and the projected trends used in the estimates. The following discussions apply to projections under both alternative II-A and alternative II-B unless otherwise indicated.

Increases in economic factors can be divided into those for payroll and those for nonpayroll expenditures. About half of hospital costs are for direct payroll expenses. This proportion has declined over the years, and a modest continuation in the decline is projected. The weighted averages of the economic factors in table A1 reflect these year-by-year proportions. Increases in average wages in the period 1966-80 generally

ranged from 5 to 7 1/2 percent per year, with somewhat higher increases increases from 1976-80. Changes in the CPI during the same period generally varied between 2 1/2 and 7 1/2 percent, with the exception of substantially higher rates of increases in 1974, 1975, 1979, and 1980. The increases in both average wages and CPI beyond 1980 are based on assumptions used in projecting experience under the OASDI program.

Increases in volume of services (as measured by admissions) are separated into (1) a part due to population growth and (2) a part due to changes in the average number of admissions per capita. The population projection used in this report is based on assumptions used in projecting experience under the OASDI program. Admission incidence rates increased on average 1.7 percent during the 10-year pre-Medicare period 1956-65; the trend in the period 1966-74 has been relatively consistent, with an average rate of increase of about 1 1/2 percent. Increases in admission incidence in the period 1975-79 averaged less than 1 percent. Increase in admission incidence for 1980 was 2.0 percent. This level is projected to taper gradually to an ultimate rate of increase that results solely from aging in the general population (i.e., admissions per capita by age and sex ultimately are assumed to be constant, so that the increases in overall average admissions per capita are due solely to changes in the mix of age and sex).

Unit input intensity changes can be analyzed and projected in terms of payroll and nonpayroll components in a manner similar to that for economic factors. The payroll component can be divided further between

unit input intensity increases related to (1) the excess of average wage increases for hospital employees over average wage increases in the general economy and (2) increases in the average number of hospital employees per admissions.

For several years preceding the beginning of the hospital insurance program, average hospital wages and salaries (as derived from data reported by the American Hosptial Association) increased at a rate of about 1 percent per year more rapidly than the rate of increases in earnings in OASDI-covered employment. During the 1966-80 period, this differential has fluctuated widely, but has averaged slightly higher than 1 percent. Several factors contributing to this differential can be identified, including (1) growth in third-party reimbursement of hospitals--through Medicare, Medicaid, and comprehensive private plans--which is likely to have weakened hospital resistance to wage demands; (2) increased proportions of highly trained and more highly paid personnel; (3) an increased degree of labor organization and activity; and (4) the fact that hospital employees historically have earned less than similarly skilled workers in other industries. Preliminary data for 1981 shows a relatively high increase in the wage differential of about 3 1/2 percent. Over the short term, the differential level is assumed to taper to a modest level. The projection assumes a continuation of this modest wage level intensity factor over the long run.

The number of hospital employees has continued to increase more rapidly than the number of admissions over the past 20 years. Increases

in employee intensity averaged 2 percent per year during the 10 years preceding Medicare. The early years of the program were marked by a substantial surge in employees per admission, followed by a period of only modest increases during the imposition of economic stabilization program controls. Many of the same factors which have affected hospital wage level differentials can be identified also as contributing to the increase in employee intensity; in addition, the increased number and complexity of services provided with a given admission have been significant factors. Preliminary data for 1981 show an increase in employee intensity of about 2.9 percent. The projection assumes a gradual tapering of this trend to reflect a lower rate of industry growth than during the earlier period.

Nonlabor unit input intensity is a composite of several heterogeneous components. These include (1) price increases for goods and services that hospitals purchase which do not parallel increases in the CPI, (2) increases in the volume of medical and other supplies purchased and used per admission, and (3) increases in medical equipment and other capital assets employed in the provision of a hospital admission. Due to a lack of data, the nonlabor intensity factor cannot be separated into its component parts and must be treated as a residual. Historically, this factor has increased at a high rate and in an erratic fashion. Increases during the 1956-65 period averaged nearly 5 1/2 percent; these were followed by an irregular series of increases during the period 1966-72 ranging between 6 and 18 1/2 percent. The second and third years of the

controlled period 1972-74 produced increases of only 2 to 3 percent, substantially below even the increases for the 10-year pre-Medicare period. The nonlabor intensity factor declined sharply in 1979, and increased slightly in 1980. The projection assumes a return to a level consistent with experience (excluding years subject to economic stabilization program controls), followed by a gradual decline to a level consistent with experience during the decade preceding Medicare. In general, there is an inverse relationship between the level of the CPI and nonlabor intensity factor. Hence, the nonlabor intensity factor under alternative II-A, which has lower CPI projections than alternative II-B, is assumed to remain at a higher level than under alternative II-B before declining to a level consistent with the pre-Medicare period.

Aggregate inpatient hospital costs—reflecting the composite of economic factors, volume of service, and unit input intensity—have exhibited a very rapid rate and irregular pattern of increases. Although the pre-Medicare period produced an average rate of increase of appproximately 10 1/2 percent, typical rates in subsequent years have tended to vary between 10 and 19 percent.

Changes in the program's share of aggregate hospital costs result from (1) changes in the proportion of the population covered, including changes due to legislation; (2) changes in the relative number and value of services received by beneficiaries; and (3) the effect of administrative actions defining the services eligible for reimbursement and affecting the level of program payment. Historical and projected changes in the hospital insurance

program's share of aggregate inpatient hospital costs appear in table A-1 with changes in the proportion of the population covered netted from the other sources. As indicated in the table, the share of hospital costs allocated to beneficiaries has fluctuated somewhat in recent years.

The increases experienced in the proportion of the population covered reflect the more rapid rate of increase in the number of persons aged 65 and over than in the total population of the United States and, beginning in mid-1973, the coverage of certain disabled beneficiaries and persons with end-stage renal disease. Increases in the proportion of the population covered are projected to continue, reflecting a continuation of the demographic shift into categories of the population which are eligible for hospital insurance protection.

Other sources which contribute to changes in the program's share of hospital costs include changes in the relative number and value of services received by beneficiaries and the effect of administrative actions defining covered services and affecting payment levels. Data are not available which would enable a quantitative separation between the two components for historical years. The projection assumes, over the long range, changes in these "other sources" only due to the effects of demographic shifts on the number of services received by beneficiaries as a proportion of the total number of hospital services provided for the entire population. Increases in the average age of beneficiaries and of persons not covered lead to higher expected levels of usage of hospital services by both groups, the net effect of which is reflected as changes in "other sources."

c. Skilled Nursing Facility and Home Health Agency Costs

Historical experience with the number of days of care covered in skilled nursing facilities under the hospital insurance program has been characterized by wide swings. The number of covered days dropped very sharply in 1970 and continued to decline through 1972. This was the result of strict enforcement of regulations separating skilled nursing from custodial care. Because of the small fraction of nursing home care covered under the program, this reduction primarily reflected the determination that Medicare was not liable for payment rather than reduced usage of services. The 1972 amendments extended benefits to persons who require skilled rehabilitative services regardless of their need for skilled nursing services (the former prerequisite for benefits). This change and subsequent related changes in regulations have resulted in significant increases in the number of services covered by the program. Recent data has indicated a decline in utilization of these services through 1980. Only modest increases are projected in skilled nursing utilization thereafter.

Increases in the average cost per day in skilled nursing facilities under the program are caused principally by increasing payroll costs for nurses and other skilled labor required. Projected rates of increase are assumed to be about the same as increases in general wages throughout the 25-year projection period. The resulting increases in the cost of skilled nursing facility services are shown in table A2.

Program experience with home health agency costs has shown a generally upward trend. The number of visits has fluctuated somewhat from year to

year, with very sharp increases appearing in the last three years. Relatively large increases are assumed for the next few years, followed by a projected pattern of increases similar to that for skilled nursing facilities. Cost per service is assumed to increase at about the same rate as increases in general wages. The resulting home health agency cost increases are shown in table A2.

d. Administrative Expenses

The costs of administering the hospital insurance program have remained relatively small, in comparison with benefit amounts, throughout the history of the program. The ratio of administrative expenses to benefit payment has generally fallen within the range of 1 to 3 percent. The short-range projection of administrative cost is based on estimates of workloads and approved budgets for intermediaries and the Health Care Financing Administration. In the long range, administrative cost increases are based on assumed increases in workloads, primarily due to growth and aging of the population, and on assumed unit cost increases of 2 percent less than the increases in average wages shown in table A1.

2. FINANCING

In order to analyze costs and to evaluate the financing of a program supported by payroll taxes, program costs must be compared on a year-by-year basis with the taxable payroll which provides the source of income for these costs. Since the vast majority of total program costs related to insured beneficiaries and since general revenue appropriations and premium payments are available to support the uninsured segments, the remainder of this report will focus on the financing for insured beneficiaries.

a. Taxable Payroll

Taxable payroll increases can be separated into a part due to increases in covered wages and a part due to increases in the number of covered workers. The taxable payroll projection used in this report is based on assumptions used in projecting experience under the OASDI program. Increases in taxable payroll assumed for this report are shown in table A2.

b. Relationship Between Program Costs and Taxable Payroll

The single most meaningful measure of program cost increases, with reference to the financing of the system, is the relationship between program cost increases and taxable payroll increases. If the rates of increase in both series are the same, a level tax rate over time will be adequate to support the program. However, to the extent that program costs increase more rapidly than taxable payroll, a schedule of increasing tax rates will be required to finance the system over time. Table A2 shows the resulting increases in program costs relative to taxable payroll over the 25-year projection period. These relative increases reduce gradually to an ultimate level of approximately 2.9 and 3.3 percent per year for alternatives II-A and II-B, respectively. The result of these increases over the duration of the projection period is a continued increase in the year-by-year ratios of program expenditures to taxable payroll, as shown in table A3.

3. SENSITIVITY TESTING OF COSTS UNDER ALTERNATIVE ASSUMPTIONS

Over the past 20 years, aggregate inpatient hospital costs for all patients have increased substantially faster than increases in average wages and prices in the general economy. As indicated in table A1, the 10-year period preceding Medicare was characterized by an average 10.4 percent increase in hospital costs, nearly 7 1/2 percent higher than the increase attributable to general wage and price increases. The 1966-71 period experienced substantially higher increases in total hospital costs, averaging 16 percent per year. Of this increase, general economic factors accounted for only 5 1/2 percent; the remaining 10 1/2 percent reflected increases in the volume of services provided and in unit input intensity. Even during the 1972-74 period of economic stabilization program controls, hospital costs increased at an average rate of about 12 1/2 percent, almost 5 1/2 percent higher than the amount attributable to increases in average wages and in the CPI. Experience for the fully decontrolled years 1975-80 shows an average annual increase in hospital costs of 15 percent, of which about 6 percent is in excess of increases in general economic factors. Preliminary indications for 1981 show hospital cost increases about 8 percent higher than wages and prices in the general economy.

The sustained, high rates of hospital cost increases in the past raise serious questions concerning future cost increases which might be anticipated. Under conventional economic wisdom, the hospital industry would not be expected to sustain indefinitely the same rate of growth, relative to the general economy, experienced during the last 20 years. However, the growth rate pattern shows no indication of halting.

The most reasonable pattern of cost increase assumptions for the future, then, would fall between the two extremes of (1) an indefinite continuation of the past levels of excess of hospital cost increases over general economic factors and (2) a decline in the near term to hospital cost increase levels approaching those for the economy as a whole.

In view of the uncertainty of future cost trends, projected costs for the hospital insurance program have been prepared under four alternative sets of assumptions. A summary of the assumptions and results is shown in table A3. The sets of assmptions labeled "Alternative II-A and Alternative II-B" form the basis for the detailed discussion of hospital cost trends and resulting program costs presented throughout this report. They represent intermediate sets of cost increase assumptions, compared with the lower cost and more optimistic alternative I and the higher cost and less optimistic alternative III. Increases in the economic factors (average wages and CPI) for the four alternatives are consistent with those underlying the OASDI report.

As noted earlier, the single most meaningful measure of hospital insurance program cost increases, with reference to the financing of the system, is the relationship between program cost increases and taxable payroll increases. The extent to which program cost increases exceed increases in taxable payroll will determine how steeply tax rates must increase to finance the system over time.

Under both sets of intermediate assumptions, program costs are projected ultimately to increase approximately 3 percent faster than increases in taxable payroll. Program expenditures, which are currently about 2 1/2 percent

of taxable payroll, increase to a level of about 6 and 7 percent by the year 2005 under alternatives II-A and II-B, respectively. Hence, if all of the projection assumptions are realized over time, hospital insurance tax rates by the end of the 25-year period will have to be substantially higher than those provided in the present financing schedule (2.9 percent of taxable payroll, for 1986 and later).

Alternatives I and III contain assumptions which result in program costs increasing, relative to taxable payroll increases, approximately 2 percent less and 2 percent more rapidly, respectively, than the results under both sets of intermediate assumptions. Under alternative I, program costs ultimately increase 1.2 percent more rapidly than increases in taxable payroll. By the year 2005, program expenditures under this alternative would be about 4.5 percent of taxable payroll. Hence, hospital insurance tax rates required by the end of the valuation period would be greater than those currently scheduled, even under the optimistic alternative I assumptions. Under alternative III, program costs ultimately increase 5.4 percent more rapidly than increases in taxable payroll. The result of this differential is a level of program expenditures in the year 2005 which is 11.0 percent of taxable payroll, about 8.1 percent higher than the 2.9 percent tax rate currently scheduled.

TABLE A1.—COMPONENTS OF HISTORICAL AND PROJECTED INCREASES IN HOSPITAL COSTS 1/
(Percent)

Calendar Year	Economic Factors: Average wages	Economic Factors: CPI	Economic Factors: Weighted average 3/	Volume of Services 2/: Total population	Volume of Services 2/: Admission incidence	Unit Input Intensity 2/: Wage level	Unit Input Intensity 2/: Employee intensity	Unit Input Intensity 2/: Nonlabor intensity	Unit Input Intensity 2/: Weighted average 3/	Aggregate Inpatient hosp.costs 4/	HI Share: Proportion of population	HI Share: Other sources	HI inpatient hospital costs
Historical Data:													
1956-65	3.7%	1.6%	3.0%	1.6%	1.7%	1.0%	2.0%	5.3%	4.1%	10.4%			
1966	5.7	3.0	4.7	1.1	.5	-4.8	8.2	8.4	5.4	11.7			
1967	5.5	2.8	4.6	1.1	-0.7	3.5	6.2	18.4	13.6	18.6			
1968	6.4	4.2	5.7	1.0	0.1	3.3	4.4	11.6	9.7	16.5	0.6%	7.5%	24.6%
1969	6.7	5.4	6.6	1.0	2.6	2.5	3.5	9.9	8.2	18.4	0.5	-3.7	15.2
1970	4.9	5.9	5.7	1.1	2.4	5.0	1.3	8.3	7.6	16.8	0.5	-5.3	12.0
1971	4.9	4.3	4.9	1.0	2.0	5.1	-0.1	6.1	5.8	13.7	0.6	-0.8	13.5
1972	7.3	3.3	5.8	0.9	1.2	0.8	0.2	11.3	5.6	13.5	0.7	-3.3	10.9
1973	6.9	6.2	6.8	0.7	2.4	-2.2	0.0	3.1	0.2	10.1	5.3	1.0	16.4
1974	7.4	11.0	9.5	0.7	3.0	-1.6	2.3	2.0	1.3	14.5	6.0	3.1	23.6
1975	6.6	9.1	8.2	0.7	1.0	3.9	2.4	10.5	8.8	18.7	2.2	1.6	22.5
1976	8.2	5.8	7.4	0.7	0.9	0.8	1.5	10.9	6.7	15.7	2.2	1.1	19.0
1977	8.0	6.5	7.4	0.8	0.0	-0.9	2.9	8.5	5.4	13.6	2.2	2.2	18.1
1978	8.2	7.6	8.2	0.8	-0.2	-0.2	2.3	5.4	3.9	12.7	1.6	0.4	14.7
1979	8.8	11.1	10.2	0.9	0.8	-0.3	1.3	0.5	0.8	12.7	1.6	2.0	16.3
1980	8.6	13.5	11.7	0.9	2.0	1.2	1.5	1.2	2.0	16.6	1.1	3.8	21.5
Projection:													
Alternative II-A													
1981	8.6	10.3	10.1	0.9	1.1	3.5	2.9	5.7	6.4	18.5	0.8	0.8	20.1
1982	8.6	6.8	8.1	0.9	1.1	1.5	2.2	8.5	6.5	16.6	0.7	-1.4	15.9
1983	6.3	6.0	6.5	0.9	0.8	1.5	2.0	8.0	6.1	14.3	0.7	0.3	15.3
1984	5.6	4.6	5.3	0.9	0.8	1.0	1.5	8.0	5.7	12.7	0.9	0.0	13.6
1985	7.4	4.8	6.2	0.9	0.7	0.5	1.0	8.0	5.3	13.1	1.3	0.3	14.7
1990	6.0	3.5	4.7	0.8	0.5	0.5	1.0	7.0	4.9	10.9	1.2	0.2	12.3
1995	5.0	3.0	3.8	0.7	0.3	0.5	0.5	6.0	4.3	9.1	0.8	0.2	10.1
2000	5.0	3.0	3.8	0.6	0.3	0.5	0.5	5.0	3.7	8.4	0.4	0.0	8.8
2005	5.0	3.0	3.8	0.6	0.3	0.5	0.5	5.0	3.7	8.4	0.5	-0.1	8.8
Alternative II-B													
1981	8.6	10.3	10.1	0.9	1.1	3.5	2.9	5.7	6.4	18.5	0.8	0.8	20.1
1982	6.6	6.9	7.2	0.9	1.1	2.5	2.7	8.5	7.3	16.5	0.7	-1.3	15.9
1983	8.1	7.9	8.4	0.9	0.8	1.5	2.0	7.5	5.9	16.0	0.7	0.3	17.0
1984	8.1	7.4	8.1	0.9	0.8	1.0	1.5	7.5	5.5	15.3	0.9	0.0	16.2
1985	6.9	6.6	7.0	0.9	0.7	0.5	1.0	7.5	5.1	13.7	1.3	0.3	15.3
1990	6.0	4.5	5.3	0.8	0.5	0.5	1.0	7.0	5.0	11.6	1.2	0.2	13.0
1995	5.5	4.0	4.6	0.7	0.3	0.5	0.5	6.0	4.4	10.0	0.8	0.2	11.0
2000	5.5	4.0	4.6	0.6	0.3	0.5	0.5	5.0	3.8	9.3	0.4	0.0	9.7
2005	5.5	4.0	4.6	0.6	0.3	0.5	0.5	5.0	3.8	9.3	0.5	-0.1	9.7

1/ Percent increase in year indicated over previous year.

2/ Based on data from the American Hospital Association through 1980.

3/ Weighted average of the individual components, with adjustments for the effects of compounding. The weightings are based on the proportions of aggregate inpatient hospital costs which are for payroll and for nonpayroll expenses. The adjustments for the effects of compounding are necessary to compensate for the fact that the various components actually are multiplicative, rather than additive as illustrated in this table.

4/ Includes hospital costs for all patients.

TABLE A2.--RELATIONSHIP BETWEEN INCREASES IN TOTAL HI PROGRAM COSTS AND INCREASES IN TAXABLE PAYROLL 1/
(Percent)

Calendar year	Inpatient hospital 2/	Skilled nursing facility 3/	Home health agency 3/	Weighted average	HI administrative costs 3/	Total HI program costs 3/	HI taxable payroll	Ratio of costs to payroll 4/
Alternative II-A								
1982	15.4%	11.7%	40.2%	16.1%	-2.2%	15.7%	9.0%	6.1%
1983	15.5	9.2	15.6	15.4	7.8	15.3	9.4	5.4
1984	14.0	9.0	11.6	13.8	6.9	13.7	8.6	4.7
1985	15.0	10.7	11.8	14.9	9.3	14.8	9.5	4.8
1990	12.4	9.1	8.9	12.3	7.4	12.2	7.3	4.6
1995	10.2	7.6	7.5	10.1	5.9	10.0	5.7	4.1
2000	8.8	6.9	6.9	8.8	5.4	8.7	5.8	2.8
2005	8.8	6.6	6.6	8.7	5.3	8.7	5.6	2.9
Alternative II-B								
1982	15.4	11.7	39.7	16.1	-2.4	15.7	6.6	8.5
1983	17.2	11.3	17.7	17.2	9.5	17.0	10.7	5.8
1984	16.6	11.6	14.1	16.4	9.5	16.3	10.3	5.4
1985	15.6	10.2	11.1	15.4	8.7	15.3	9.3	5.5
1990	13.1	9.0	9.0	13.0	7.4	12.9	7.2	5.3
1995	11.1	8.1	8.0	11.0	6.5	11.0	6.1	4.5
2000	9.7	7.4	7.4	9.7	5.9	9.6	6.2	3.2
2005	9.7	7.0	7.0	9.6	5.8	9.6	6.1	3.3

1/ Percent increase in year indicated over previous year.

2/ This column differs slightly from the last column of table A1, since table A1 includes all persons eligible for HI protection while this table excludes noninsured persons.

3/ Costs attributable to insured beneficiaries only. Benefits and administrative costs for noninsured persons are financed through general revenue transfers and premium payments rather than through payroll taxes.

4/ Percent increase in the ratio of program expenditures to taxable payroll. This is equivalent to the differential between the increase in program costs and the increase in taxable payroll.

NOTE: Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

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APPENDIX B

DETERMINATION AND ANNOUNCEMENT OF THE INPATIENT HOSPITAL DEDUCTIBLE FOR 1982*

Under the authority in section 1831(b)(2) of the Social Security Act (42 U.S.C. 1395e(b)(2)), I have determined that the Medicare inpatient deductible for 1982 will be $260.

Section 1813 provides for an inpatient hospital deductible and certain coinsurance amounts to be deducted from the amount payable by Medicare for inpatient hospital services and post-hospital extended care services furnished an individual. Section 1813(b)(2) requires the Secretary of HHS to determine and publish, between July 1 and October 1 of each year, the amount of the inpatient hospital deductible applicable for the following calendar year.

Because the coinsurance amounts in section 1813 are fixed percentages of the inpatient hospital deductible for services furnished in the same calendar year, the increase in the deductible has the effect of also increasing the amount of coinsurance the Medicare beneficiary must pay. Thus, for inpatient hospital services or post-hospital extended care services furnished in 1982, the daily coinsurance of the 61st through 90th days of hospitalization (1/4 of the inpatient hospital deductible) will be $65; the daily coinsurance for lifetime reserve days (1/2 of the inpatient hospital deductible) will be $130; and the daily coinsurance for the 21st through the 100th days of post-hospital extended care services in a skilled nursing facility (1/8 of the inpatient hospital deductible) will be $32.50.

*This statement was published in the Federal Register for September 24, 1981, (Vol. 46, No. 185, p. 47115).

On August 13, 1981, Public Law 97-35 amended section 1813 of the Social Security Act in two ways. First, section 2131 of Public Law 97-35 bases the coinsurance amount on the inpatient hospital deductible in effect when the services are furnished, rather than on the deductible in effect at the beginning of the beneficiary's spell of illness (benefit period). Congress explained that this change will not only reduce Medicare program costs, but will also simplify administration of the program by making the amount of coinsurance the same for all services received during a calendar year. Previously, before calculating the amount of coinsurance for which the beneficiary was responsible, HCFA had to determine first when each spell of illness began.

Secondly, section 2132 of Public Law 97-35 increases the basis in the formula for the deductible calculation from $40 to $45, beginning January 1, 1982. For 1982, this change in the basis accounts for an increase in the deductible and coinsurance amounts of approximately 12.1 percent. The remainder of the overall 27 percent increase is due to the increase in the average per diem hospital cost. Congress explained that the inpatient hospital deductible is supposed to increase each year to reflect the covered cost of one day's hospital care, but in reality the calculation actually lags about two years behind actual hospital cost increases. Congress believes that the necessity of achieving a reduction in Medicare program costs warrants making the deductible more reflective of the current cost of one day's hospital care (page 317 of H.R. Rep. No. 97-158, 97th Congress, 1st Session (1981)).

Under the amended formula in the law, the deductible for calendar year 1982 must be equal to $45 multiplied by the ratio of (1) the current average per diem rate for inpatient hospital services for calendar year 1980 to (2) the average per diem rate for such services in 1966. The amount so determined is rounded to the nearest multiple of $4. The average per diem rates are based on the amounts paid to participating hospitals by Medicare for inpatient services to insured individuals, plus the deductible and coinsurance amounts.

The average per diem rate for a calendar year is computed from the inpatient hospital bills for all beneficiaries. Each bill shows the number of inpatient days of care and the interim cost (the sum of interim reimbursement, deductible, and coinsurance). The data are summarized for each year, and an average interim per diem rate computed that accurately reflects interim costs on an accrual basis.

In order to reflect the change in the average per diem hospital cost under the program properly, the average interim cost must be adjusted to show the effect of final cost settlements made with each participating hospital after the end of its accounting year. The final settlements adjust the interim payment to the hospital to the actual full cost of providing covered services to beneficiaries. To the extent that the ratio of final cost to interim cost for 1980 differs from the ratio of final cost to interim cost for 1966, the increase in average interim per diem costs will not coincide with the increase in actual cost that has occurred.

The current average interim per diem rate for inpatient hospital services for calendar year 1980, based on tabulated interim cost, is

$221.99; the corresponding amount for 1966 is $37.92. The averages are based on approximately 105 million days of hospitalization in 1980 and 30 million days in 1966 (last six months of the year). The ratio of final cost to interim cost is approximately 1.047 for 1980 and 1.055 for 1966. Thus, the inpatient hospital deductible is $45 x (221.99 x 1.047)/(37.92 x 1.055) = $261.44, which is rounded to $260.

IMPACT ANALYSES

The inpatient hospital deductible and coinsurance amounts for the calendar year 1982 will be 27 percent higher than the 1981 amounts. The inpatient hospital deductible increased from $204 to $260; the daily coinsurance for the 61st through 90th days of hospitalization increased from $51 to $65; the daily coinsurance for lifetime reserve days increased from $102 to $130; and the daily coinsurance for the 21st through 100th days of post-hospital extended care sevices in a skilled nursing facility increased from $25.50 to $32.50.

The estimated cost to beneficiaries due to these increases is $560 million. About half, or $280 million, is due to the change in the law which increased from $40 to $45, the basis in the formula used to compute the deductible. The remaining $280 million increase is due to inflation. These amounts are based on an estimated 7.3 million beneficiaries who will have 8.3 million benefit periods and use 4.7 million coinsurance days and 1.2 million lifetime reserve days in 1982.

An additional $10 million will be paid by beneficiaries because of the change in the law which bases coinsurance amounts on the deductible in

effect when the service is provided instead of the year in which the benefit period began. This provision will only affect beneficiaries who have benefit periods that overlap two or more calendar years.

REGULATORY FLEXIBILITY ACT

The Regulatory Flexibility Act requires that an agency prepare a regulatory flexibility analysis for a proposed rule, or a final rule issued after a proposal, if a rule would have a significant economic impact on a substantial number of small businesses, small non-profit organizations, or small governmental jurisdictions. This notice merely announces (as required by section 1813 of the Social Security Act) amounts beneficiaries are responsible for in the cost of their own hospitalization or treatment in a skilled nursing facility. This announcement is made annually in the form of a notice. Because this notice is not a proposed rule or final rule issued after a proposal, no analysis is required under the Regulatory Flexibility Act.

However, we have determined that this notice will not have a significant economic impact on a substantial number of small entities. The increase of $570 million represents only 1.8 percent of the $32.5 billion which HCFA will pay to hospitals and skilled nursing facilities in 1982 for inpatient services provided to Medicare beneficiaries. That amount will be met by Medicare beneficiaries. Because this notice will not result in a significant economic impact on hospitals or skilled nursing facilities or other small entities, the Secretary certifies that a regulatory flexibility analysis is not required.

Dated:

Richard S. Schweiker
Secretary

APPENDIX C

DETERMINATION AND ANNOUNCEMENT OF THE HOSPITAL INSURANCE MONTHLY PREMIUM RATE FOR THE UNINSURED AGED, FOR THE 12-MONTH PERIOD BEGINNING JULY 1, 1982*

Under the authority in section 1818(d)(2) of the Social Security Act (42 U.S.C. 139512(d)(2)), I have determined that the monthly Medicare hospital insurance premium for the uninsured aged for the 12 months beginning July 1, 1982, is $113.

Section 1818 of the Social Security Act provides for voluntary enrollment in the hospital insurance program (Part A of Medicare), subject to payment of a monthly premium, of certain persons age 65 and older who are uninsured for social security or railroad retirement benefits and do not otherwise meet the requirements for entitlement to hospital insurance. (Persons insured under the Social Security or Railroad Retirement Acts need not pay premiums for hospital insurance.)

Section 1818(d)(2) of the Act requires the Secretary to determine and publish, during the last quarter of each calendar year, the amount of the monthly Part A premium for voluntary enrollment for the 12-month period beginning with the following July 1. The formula specified in this section also requires that, for the period beginning July 1, 1982, the 1973 base year premium ($33) be multiplied by the ratio of (1) the 1982 inpatient hospital deductible to (2) the 1973 inpatient hospital deductible, rounded to the nearer multiple of $1 or, if midway between multiples of $1, to the next higher multiple of $1.

*This statement was published in the Federal Register for December 31, 1981, (Vol.46, No. 251, p. 63389).

Under section 1813(b)(2) of the Act, the 1982 inpatient hospital deductible was determined to be $260. (See 46 FR 47115, September 24, 1981.) The 1973 deductible was actuarially determined to be $76, although the 1973 deductible was actually promulgated to be only $72, to comply with a ruling of the Cost of Living Council. (See 37 FR 21452, October 11, 1972.) The monthly premium for the 12-month period beginning July 1, 1982, has been calculated using the $76 deductible for 1973, since this more closely satisfies the intent of the law. Thus, the monthly hospital insurance premium is $33 x (260/76) = $112.89, which is rounded to $113.

IMPACT ANALYSES

The monthly hospital insurance premium for the uninsured aged for the 12-month period beginning July 1, 1982, will increase to $113. That amount is 27 percent higher than the $89 monthly premium amount for the previous 12-month period.

The estimated cost of this increase to the approximately 24,000 enrollees who do not meet the requirements for entitlement to hospital insurance will be about $7,000,000.

Because this notice merely announces an amount required by the formula specified in section 1818(d)(2) of the Act, and does not alter any regulation or policy, no analyses under Executive Order 12291 or the Regulatory Flexibility Act, Pub. L. 96-354, are required.

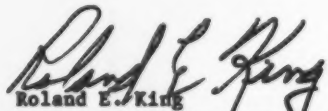
Dated:

Richard S. Schweiker
Secretary

APPENDIX D

STATEMENT OF ACTUARIAL OPINION

It is my opinion that (1) the methodology used herein is based upon sound principles of actuarial practice and (2) the assumptions used and the resulting cost estimates are in the aggregate reasonable for the purpose of evaluating the actuarial and financial status of the Federal Hospital Insurance Trust Fund, taking into account the experience and expectations of the program.



Roland E. King
Fellow of the Society of Actuaries
Member of the American Academy of Actuaries
Director, Office of Financial and Actuarial Analysis
Health Care Financing Administration

TABLE A3.—SUMMARY OF ALTERNATIVE COST PROJECTIONS FOR THE HOSPITAL INSURANCE PROGRAM
(Percent)

Calendar year	Increases in aggregate inpatient hospital costs 1/				Changes in the relationship between costs and payroll 2/			Expenditures as a percent of taxable payroll
	Average wages	CPI	Volume & intensity	Total	Program costs 3/	Taxable payroll	Ratio of costs to payroll	
				ALTERNATIVE I				
1982	8.2%	6.3%	8.9%	16.5%	15.7%	8.7%	6.4%	2.55%
1983	7.3	5.9	7.7	14.7	15.7	11.1	4.2	2.66
1984	7.5	4.6	7.2	13.5	14.6	10.7	3.5	2.75
1985	7.0	4.2	6.4	12.1	13.8	9.8	3.6	2.85
1990	5.2	2.2	4.1	7.7	9.2	5.5	3.5	3.34
1995	4.5	2.0	4.0	7.9	7.9	5.1	2.6	3.88
2000	4.5	2.0	3.3	6.2	6.6	5.3	1.2	4.24
2005	4.5	2.0	3.2	6.1	6.5	5.2	1.2	4.50
				ALTERNATIVE II-A				
1982	8.6	6.8	8.5	16.6	15.7	9.0	6.1	2.54
1983	6.3	6.0	7.8	14.3	15.3	9.4	5.4	2.68
1984	5.6	4.6	7.4	12.7	13.7	8.6	4.7	2.80
1985	7.4	4.8	6.9	13.1	14.8	9.5	4.8	2.94
1990	6.0	3.5	6.2	10.9	12.2	7.3	4.6	3.68
1995	5.0	3.0	5.3	9.1	10.0	5.7	4.1	4.59
2000	5.0	3.0	4.6	8.4	8.7	5.8	2.8	5.40
2005	5.0	3.0	4.6	8.4	8.7	5.6	2.9	6.18
				ALTERNATIVE II-B				
1982	6.6	6.9	9.3	16.5	15.7	6.6	8.5	2.60
1983	8.1	7.9	7.6	16.0	17.0	10.7	5.8	2.75
1984	8.1	7.4	7.2	15.3	16.3	10.3	5.4	2.90
1985	6.9	6.6	6.7	13.7	15.3	9.3	5.5	3.06
1990	6.0	4.5	6.3	11.6	12.9	7.2	5.3	3.93
1995	5.5	4.0	5.4	10.0	11.0	6.1	4.5	5.00
2000	5.5	4.0	4.7	9.3	9.6	6.2	3.2	6.01
2005	5.5	4.0	4.7	9.3	9.6	6.1	3.3	7.03
				ALTERNATIVE III				
1982	6.3	7.2	9.3	16.5	15.7	6.2	8.9	2.61
1983	7.3	9.6	7.1	16.0	16.9	8.5	7.7	2.81
1984	7.8	9.6	7.3	16.5	17.4	9.2	7.5	3.02
1985	9.2	9.2	8.8	18.3	19.9	11.6	7.5	3.25
1990	8.0	7.2	8.2	15.9	17.2	9.2	7.3	4.58
1995	6.2	5.2	6.7	13.3	13.2	6.2	6.6	6.42
2000	6.0	5.0	6.0	11.4	11.7	6.2	5.3	8.53
2005	6.0	5.0	6.0	11.4	11.7	6.0	5.4	11.00

1/ Percent increase in the year indicated over the previous year. Includes hospital costs for all patients.
2/ Percent increase in the year indicated over the previous year.
3/ Includes cost attributable to insured beneficiaries only.

NOTE: Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.